House of Representatives

File No. 816

General Assembly

January Session, 2005

(Reprint of File No. 254)

Substitute House Bill No. 6619
As Amended by House Amendment
Schedule "A"

Approved by the Legislative Commissioner
May 28, 2005

AN ACT CONCERNING MEDICAL DISCOUNT PLANS.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. (NEW) (*Effective July 1, 2005*) (a) As used in this section and section 2 of this act:

(1) "Affiliate" means a person that directly or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, a health insurer, health care center, hospital service corporation, medical service corporation or fraternal benefit society licensed in this state;

(2) "Consumer" means: (A) A person to whom a medical discount plan is marketed or advertised, or (B) a member, as defined in this subsection;

(3) "Medical discount plan" means a business arrangement or contract in which a person, in exchange for payment, provides access for its members to providers of health care services and the right to receive health care services from those providers at a discount.

"Medical discount plan" does not include a product that (A) is otherwise subject to regulation or approval under title 38a of the general statutes, or (B) costs less than twenty-five dollars, annually, in the aggregate;

(4) "Medical discount plan organization" means a person that (A) establishes a medical discount plan, (B) contracts with providers, provider networks or other medical discount plan organizations to provide health care services at a discount to medical discount plan members, and (C) determines the fees charged to the members for the medical discount plan. "Medical discount plan organization" does not include a health insurer, health care center, hospital service corporation, medical service corporation or fraternal benefit society licensed in this state or any affiliate of such health insurer, health care center, hospital service corporation, medical service corporation or fraternal benefit society;

(5) "Health care services" means any care, service or treatment of an illness or dysfunction of, or injury to, the human body. "Health care services" includes physician care, inpatient care, hospital surgical services, emergency medical services, ambulance services, dental care services, vision care services, mental health care services, substance abuse services, chiropractic services, podiatric services, laboratory test services and the provision of medical equipment or supplies. "Health care services" does not include pharmaceutical supplies or prescriptions;

(6) "Member" means an individual who pays for the right to receive the benefits of a medical discount plan; and

(7) "Person" means a person, as defined in section 38a-1 of the general statutes.

(b) No person may market, advertise or sell to a resident of this state a medical discount plan or any plan material that: (1) Fails to provide to the consumer a clear and conspicuous disclosure that the medical discount plan is not insurance and that the plan only provides for

discounted health care services from participating providers within the plan; (2) uses in its marketing materials, advertisements, brochures or member discount cards the term "insurance", "health plan", "coverage", "copay", "copayments", "preexisting conditions", "guaranteed issue", "premium", "PPO", "preferred provider organization" or any other term that could reasonably mislead a person into believing the medical discount plan is insurance, except that such terms may be used as a disclaimer of any relationship between the medical discount plan and insurance; (3) fails to provide the name, address and telephone number of the administrator of the medical discount plan; (4) fails to make available to the consumer through a toll-free telephone number, upon request of the consumer, a complete and accurate list of the participating providers within the plan in the consumer's local area and a list of the services for which the discounts are applicable; (5) fails to make a printed copy of such list available to the consumer upon request commencing with the time the plan is purchased or fails to update the list at least once every six months; (6) fails to use plain language to describe the discounts or access to discounts offered and such failure results in representations of the discounts that are misleading, deceptive or fraudulent; (7) fails to provide the consumer notice of the right to cancel such medical discount plan; (8) offers discounted health care services or products that are not authorized by a contract with each provider listed in conjunction with the medical discount plan; (9) fails to allow a consumer to cancel a medical discount plan not later than thirty days after the date payment is received by the medical discount plan; (10) with respect to a consumer who cancels a medical discount plan pursuant to subdivision (9) of this subsection, fails to guarantee a refund of all membership fees paid to the medical discount plan by the consumer, excluding a reasonable one-time processing fee, not later than thirty days after the member gives timely notification of cancellation of the plan to the medical discount plan organization; or (11) fails to (A) provide at least one member discount card for each member as proof of membership, and (B) prominently display on such member discount card a statement that the medical discount plan is not insurance.

(c) Any person who knowingly operates as a medical discount plan organization in violation of this section shall be fined not more than ten thousand dollars. Any person who knowingly aids and abets another that the person knew or reasonably should have known was operating as a medical discount plan organization in violation of this section shall be fined not more than ten thousand dollars.

(d) Any person who collects fees for purported membership in a medical discount plan but fails to provide the promised benefits shall be subject to the penalties for larceny under sections 53a-122 to 53a-125b, inclusive, of the general statutes, depending on the amount involved.

(e) Any person licensed in this state as a health insurer, health care center, hospital service corporation, medical service corporation or fraternal benefit society, or any affiliate owned or controlled by such health insurer, health care center, hospital service corporation, medical service corporation or fraternal benefit society, may offer medical discount plans in this state pursuant to such licensure.

Sec. 2. (NEW) (*Effective January 1, 2006*) (a) Before doing business in this state as a medical discount plan organization, an entity shall:

(1) Be a corporation, limited liability company, limited liability partnership, or other legal entity organized under the laws of this state or, if a foreign corporation or other foreign entity, authorized to transact business in this state; and

(2) Obtain a license as a medical discount plan organization from the Insurance Commissioner in accordance with this section. The entity shall file an application for a license to operate as a medical discount plan organization with the commissioner on such form as the commissioner prescribes. Such application shall be sworn to by an officer or authorized representative of the applicant, under penalty of false statement, and be accompanied by (A) a copy of the applicant's articles of incorporation, including all amendments; (B) a copy of the applicant's bylaws; (C) a list of the names, addresses, official positions

and biographical information of the medical discount plan organization and the individuals who are responsible for conducting the applicant's affairs, including, but not limited to, all members of the board of directors, board of trustees, executive committee, or other governing board or committee, the officers, contracted management company personnel, and any person or entity owning or having the right to acquire ten per cent or more of the voting securities of the applicant, which listing shall fully disclose the extent and nature of any contracts or arrangements between the applicant and any individual who is responsible for conducting the applicant's affairs, including any possible conflicts of interest; (D) for each individual listed in subparagraph (C) of this subdivision as being responsible for conducting the applicant's affairs, a complete biographical statement on forms prescribed by the commissioner; (E) a statement generally describing the applicant, its personnel and the health care services to be offered; (F) a copy of the form of all contracts made or to be made between the applicant and any providers or provider networks regarding the provision of health care services to members; (G) a copy of the form of any contract made or to be made between the applicant and any person listed in subparagraph (C) of this subdivision; (H) a copy of the form of any contract made or to be made between the applicant and any person for the performance on the applicant's behalf of any function, including, but not limited to, marketing, administration, enrollment and subcontracting for the provision of health care services to members; (I) a copy of the applicant's most recent financial statements audited by an independent certified public accountant, or, in the case of an applicant that is a subsidiary of a person or parent corporation that prepares audited financial statements reflecting the consolidated operations of the person or parent corporation, a copy of the person's or parent corporation's most recent financial statements audited by an independent certified public accountant, provided the person or parent corporation also issues a written guarantee that the minimum capital requirements of the applicant required by this section will be met; (J) a description of the proposed method of marketing; (K) a description of the subscriber

complaint procedures to be established and maintained; and (L) the fee for a medical discount plan organization license set forth in section 38a-11 of the general statutes, as amended by this act. For purposes of this subdivision, a "contract to be made" shall be determined based on the information known to the applicant on the date the information is filed with the commissioner.

(b) If the commissioner finds that the applicant is in compliance with the requirements of this section the commissioner shall issue the applicant a license as a medical discount plan organization which shall expire one year after the date of issue. The commissioner shall renew the license if the commissioner finds that the licensee is in compliance with the requirements of this section and the licensee has paid the renewal fee set forth in section 38a-11 of the general statutes, as amended by this act.

(c) Prior to applying for a license from the commissioner, a medical discount plan organization shall establish an Internet web site that contains the information described in subsection (r) of this section.

(d) Any license or renewal fee received pursuant to this section shall be deposited in the Insurance Fund established in section 38a-52a of the general statutes.

(e) Nothing in this section shall require a provider who provides discounts to the provider's own patients to obtain or maintain a license as a medical discount plan organization.

(f) Each provider who offers health care services to members under a medical discount plan shall provide such services pursuant to a written agreement. The agreement may be entered into directly by the provider or by a provider network to which the provider belongs.

(g) A provider agreement shall include: (1) A list of the services and products to be provided at a discount; (2) the amount of the discounts or, alternatively, a fee schedule that reflects the provider's discounted rates; and (3) a requirement that the provider will not charge members

more than the discounted rates.

(h) A provider agreement between a medical discount plan organization and a provider network shall require that the provider network have written agreements with its providers that: (1) Contain the terms set forth in subsection (g) of this section; (2) authorize the provider network to contract with the medical discount plan organization on behalf of the provider; and (3) require the network to maintain an up-to-date list of its contracted providers and to provide that list on a quarterly basis to the medical discount plan organization. No medical discount plan organization may enter into or renew a contractual relationship with a provider network that is not licensed in accordance with section 38a-479aa of the general statutes.

(i) The medical discount plan organization shall maintain a copy of each active agreement that it has entered into with a provider or provider network.

(j) Each medical discount plan organization shall at all times (1) maintain a net worth of at least two hundred fifty thousand dollars, or (2) post a surety bond in the amount of one hundred thousand dollars.

(k) The commissioner may not issue or renew a license under this section unless the medical discount plan organization has (1) a net worth of at least two hundred fifty thousand dollars, or (2) posted a surety bond in the amount of one hundred thousand dollars.

(l) The commissioner may suspend the authority of a medical discount plan organization to enroll new members, revoke any license issued to a medical discount plan organization, refuse to renew a license of a medical discount plan organization or order compliance if the commissioner finds that any of the following conditions exist:

(1) The organization is not operating in compliance with this section or section 1 of this act;

(2) The organization does not have the minimum net worth required

by this section;

(3) The organization has advertised, sold or attempted to sell its services in such a manner as to misrepresent its services or capacity for service or has engaged in deceptive, misleading or unfair practices with respect to advertising or sales;

(4) The organization is not fulfilling its obligations as a medical discount plan organization; or

(5) The continued operation of the medical discount plan organization would be hazardous to its members.

(m) If the commissioner has reasonable cause to believe that grounds for the suspension, nonrenewal or revocation of a license exist, the commissioner shall notify the medical discount plan organization in writing specifically stating the grounds for suspension, nonrenewal or revocation.

(n) When the license of a medical discount plan organization is surrendered, nonrenewed or revoked, the organization shall, immediately following the effective date of the order, wind up and settle the affairs transacted under the license. The organization may not engage in any further marketing, advertising, sales, collection of fees or renewal of contracts as a medical discount plan organization.

(o) The commissioner shall, in any order suspending the authority of a medical discount plan organization to enroll new members, specify the period during which the suspension is to be in effect and the conditions, if any, which must be met by the medical discount plan organization prior to reinstatement of its license to enroll new members. The commissioner may rescind or modify the order of suspension prior to the expiration of the suspension period.

(p) The commissioner may not reinstate a license: (1) Unless reinstatement is requested by the medical discount plan organization, and (2) if the commissioner finds that the circumstances which led to

the suspension still exist or are likely to recur.

(q) Each medical discount plan organization shall provide the commissioner at least thirty days advance written notice of any change in the medical discount plan organization's name, address, principal business address or mailing address.

(r) Each medical discount plan organization shall maintain an up-to-date list of the names and addresses of the providers with which it has contracted on an Internet web site, the address of which shall be prominently displayed on all its marketing materials, advertisements, brochures and member discount cards. The list shall include providers with whom the medical discount plan organization has contracted directly as well as providers who will provide services to the organization's members as part of a provider network with which the medical discount plan organization has contracted.

(s) Each medical discount plan organization shall (1) prominently display on any member discount card the names or identifying logos or trademarks of any provider networks with whom the medical discount plan organization has a contract, and (2) provide the names of such provider networks to members upon request.

(t) The commissioner may adopt regulations, in accordance with chapter 54 of the general statutes, to implement the provisions of this section.

(u) Any person who violates any provision of this section shall be fined not more than two thousand dollars.

Sec. 3. Subsection (a) of section 38a-11 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2006*):

(a) The commissioner shall demand and receive the following fees: (1) For the annual fee for each license issued to a domestic insurance company, one hundred dollars; (2) for receiving and filing annual

reports of domestic insurance companies, twenty-five dollars; (3) for filing all documents prerequisite to the issuance of a license to an insurance company, one hundred seventy-five dollars, except that the fee for such filings by any health care center, as defined in section 38a-175, shall be one thousand one hundred dollars; (4) for filing any additional paper required by law, fifteen dollars; (5) for each certificate of valuation, organization, reciprocity or compliance, twenty dollars; (6) for each certified copy of a license to a company, twenty dollars; (7) for each certified copy of a report or certificate of condition of a company to be filed in any other state, twenty dollars; (8) for amending a certificate of authority, one hundred dollars; (9) for each license issued to a rating organization, one hundred dollars. In addition, insurance companies shall pay any fees imposed under section 12-211; (10) a filing fee of twenty-five dollars for each initial application for a license made pursuant to section 38a-769; (11) with respect to insurance agents' appointments: (A) A filing fee of twenty-five dollars for each request for any agent appointment; (B) a fee of forty dollars for each appointment issued to an agent of a domestic insurance company or for each appointment continued; and (C) a fee of twenty dollars for each appointment issued to an agent of any other insurance company or for each appointment continued, except that no fee shall be payable for an appointment issued to an agent of an insurance company domiciled in a state or foreign country which does not require any fee for an appointment issued to an agent of a Connecticut insurance company; (12) with respect to insurance producers: (A) An examination fee of seven dollars for each examination taken, except when a testing service is used, the testing service shall pay a fee of seven dollars to the commissioner for each examination taken by an applicant; (B) a fee of forty dollars for each license issued; and (C) a fee of forty dollars for each license renewed; (13) with respect to public adjusters: (A) An examination fee of seven dollars for each examination taken, except when a testing service is used, the testing service shall pay a fee of seven dollars to the commissioner for each examination taken by an applicant; and (B) a fee of one hundred twenty-five dollars for each license issued or renewed;

(14) with respect to casualty adjusters: (A) An examination fee of ten dollars for each examination taken, except when a testing service is used, the testing service shall pay a fee of ten dollars to the commissioner for each examination taken by an applicant; (B) a fee of forty dollars for each license issued or renewed; and (C) the expense of any examination administered outside the state shall be the responsibility of the entity making the request and such entity shall pay to the commissioner one hundred dollars for such examination and the actual traveling expenses of the examination administrator to administer such examination; (15) with respect to motor vehicle physical damage appraisers: (A) An examination fee of forty dollars for each examination taken, except when a testing service is used, the testing service shall pay a fee of forty dollars to the commissioner for each examination taken by an applicant; (B) a fee of forty dollars for each license issued or renewed; and (C) the expense of any examination administered outside the state shall be the responsibility of the entity making the request and such entity shall pay to the commissioner one hundred dollars for such examination and the actual traveling expenses of the examination administrator to administer such examination; (16) with respect to certified insurance consultants: (A) An examination fee of thirteen dollars for each examination taken, except when a testing service is used, the testing service shall pay a fee of thirteen dollars to the commissioner for each examination taken by an applicant; (B) a fee of two hundred dollars for each license issued; and (C) a fee of one hundred twenty-five dollars for each license renewed; (17) with respect to surplus lines brokers: (A) An examination fee of ten dollars for each examination taken, except when a testing service is used, the testing service shall pay a fee of ten dollars to the commissioner for each examination taken by an applicant; and (B) a fee of five hundred dollars for each license issued or renewed; (18) with respect to fraternal agents, a fee of forty dollars for each license issued or renewed; (19) a fee of thirteen dollars for each license certificate requested, whether or not a license has been issued; (20) with respect to domestic and foreign benefit societies shall pay: (A) For service of process, twenty-five dollars for each person or

insurer to be served; (B) for filing a certified copy of its charter or articles of association, five dollars; (C) for filing the annual report, ten dollars; and (D) for filing any additional paper required by law, three dollars; (21) with respect to foreign benefit societies: (A) For each certificate of organization or compliance, four dollars; (B) for each certified copy of permit, two dollars; and (C) for each copy of a report or certificate of condition of a society to be filed in any other state, four dollars; (22) with respect to reinsurance intermediaries: A fee of five hundred dollars for each license issued or renewed; (23) with respect to viatical settlement providers: (A) A filing fee of thirteen dollars for each initial application for a license made pursuant to section 38a-465a; and (B) a fee of twenty dollars for each license issued or renewed; (24) with respect to viatical settlement brokers: (A) A filing fee of thirteen dollars for each initial application for a license made pursuant to section 38a-465a; and (B) a fee of twenty dollars for each license issued or renewed; (25) with respect to viatical settlement investment agents: (A) A filing fee of thirteen dollars for each initial application for a license made pursuant to section 38a-465a; and (B) a fee of twenty dollars for each license issued or renewed; (26) with respect to preferred provider networks, a fee of two thousand five hundred dollars for each license issued or renewed; (27) with respect to rental companies, as defined in section 38a-799, a fee of forty dollars for each permit issued or renewed; (28) with respect to medical discount plan organizations licensed under section 2 of this act, a fee of five hundred dollars for each license issued or renewed; and **[**(28)**]** (29) with respect to each duplicate license issued a fee of twenty-five dollars for each license issued.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*July 1, 2005*	New section
Sec. 2	*January 1, 2006*	New section
Sec. 3	*January 1, 2006*	38a-11(a)

The following fiscal impact statement and bill analysis are prepared for the benefit of members of the General Assembly, solely for the purpose of information, summarization, and explanation, and do not represent the intent of the General Assembly or either House thereof for any purpose:

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Effect	FY 06 $	FY 07 $
Insurance Dept.; Judicial Dept.	GF & IF - Revenue Gain	Minimal	Minimal
Judicial Dept. (Probation); Correction, Dept.	GF - Cost	Potential Minimal	Potential Minimal

Note: GF=General Fund; IF = Insurance Fund

Municipal Impact: None

Explanation

The bill allows the Insurance Commissioner to issue and annually renew a license for medical discount health plan organizations if the organization meets certain requirements and pays a $500 annual renewal fee. It also allows the Insurance Commissioner to levy certain fines for medical discount health plan organization law violations. For example, any person who operates as, or aids and abets another operating as, a medical discount health plan organization shall be fined up to ten thousand dollars. This fees and potential fines would be deposited in the Insurance Fund and would result in a minimal revenue gain.

The bill also establishes criminal larceny penalties for any person who collects fees for purported membership in such a plan but fails to provide the promised benefits. To the extent that these changes increase the likelihood that offenders would be prosecuted or receive harsher penalties, a potential revenue gain from criminal fines and potential cost for incarceration and/or probation supervision in the community exist. It is anticipated that relatively few fines would be imposed on an annual basis, and, consequently, any revenue gain

under the bill is expected to be minimal.[1]

House "A" reduced certain fines and fees in the bill and therefore reduced the amount of revenue gain.

[1] On average, it costs the state $2,150 to supervise an offender on probation in the community as compared to $35,040 to incarcerate the offender (note that both figures include fringe benefits).

OLR Bill Analysis
sHB 6619 (as amended by House "A")*

AN ACT CONCERNING DISCOUNT HEALTH PLANS

SUMMARY:
This bill establishes a regulatory framework for medical discount plans and organizations that offer such plans. It establishes requirements for (1) incorporation and licensure, (2) net worth, (3) provider agreements, (4) advertising and plan material content, and (5) consumer disclosures. It also establishes fines and penalties for violations and authorizes the commissioner to adopt implementing regulations.

*House Amendment "A" replaces the original bill with similar provisions to regulate medical discount plans. It eliminates requirements that (1) an application for licensure include a background investigation report and fingerprints for each person responsible for conducting the applicant's affairs; (2) an organization give the commissioner an annual financial statement, subject to late filing fines; and (3) an organization give a member an itemized written notice of fees when the discount plan is sold with other products. The amendment gives an organization the option to post a $100,000 surety bond instead of maintaining net worth of $250,000 and requires an organization to (1) include a contracted provider network's logo on member discount cards, (2) provide a member discount card to each member, and (3) post a prominent disclaimer on the member discount cards that the plan is not insurance. It requires a contracted provider network to give a discount plan organization an updated provider listing quarterly, instead of monthly. It also reduces the annual discount plan organization license fee from $5,000 to $500.

EFFECTIVE DATE: January 1, 2006, except for the prohibition on marketing, advertising, or selling plans that do not meet the mandatory plan provisions and related fines, which are effective July 1, 2005.

DEFINITIONS

A "medical discount plan" is an arrangement or contract that allows people who pay a membership fee access to health care providers who give those members discounted services. It does not include a product (1) already subject to regulation or approval by the insurance commissioner or (2) that costs less than $25 annually. Although not specified, the cost apparently refers to a consumer's cost to join a medical discount plan.

A "medical discount plan organization" is a person who establishes a medical discount plan, contracts with providers or other medical discount plan organizations to provide discounted health care services to members, and sets the membership fee. A health insurer, HMO, hospital or service corporation, or fraternal benefit society, or an affiliate of any such entity is not a medical discount organization, but can offer medical discount plans.

License Requirements

A medical discount plan organization must be a corporation, limited liability company, limited liability partnership, or other entity organized in Connecticut or a foreign corporation or entity authorized to transact business in Connecticut. It must file a completed license application with the insurance commissioner on a form she prescribes and an officer must swear to it under penalty of false statement. The application must include the applicant's articles of incorporation and bylaws and the names, addresses, official positions, and biographical information of (1) the medical discount plan organization and the individuals responsible for conducting its affairs and (2) any person or entity owning or having the right to acquire 10% or more of the applicant's voting securities. It must fully disclose any arrangements or possible conflicts of interest between these individuals and for each individual, provide a complete biographical statement.

The application must also include:

1. a statement describing the applicant, its personnel, and the services to be offered;

2. a copy of all contracts made or to be made between the applicant and any

a. person listed above;

b. providers or provider networks for health services; and

c. person delegating functions on the applicant's behalf, including marketing, administration, enrollment, and subcontracting health service delivery;

3. the applicant's most recent independent certified public accountant-audited financial statements or its parent company's financial statements as long as the parent company guarantees the applicant's minimum capital requirement;

4. a proposed marketing plan;

5. a description of the required subscriber complaint procedures; and

6. a $500 license fee.

Each medical discount plan organization must maintain a net worth of at least $250,000 or post a $100,000 surety bond.

Before applying for a license, the applicant must establish an Internet web site to list providers contracted with the medical discount plan.

If the applicant meets all requirements, the commissioner issues it a medical discount plan organization license, which expires one year from issue. She must renew it annually if the organization remains in compliance and pays a $500 renewal fee. License fees are deposited into the Insurance Fund.

Exemption

A health care provider who gives discounts to his own patients is exempt from the licensing requirement.

PROVIDER AGREEMENTS

A provider who offers health services under a medical discount plan must have a written agreement with the medical discount plan organization or belong to a provider network that does.

A provider agreement must include (1) the discounted services and products; (2) the discount amounts or a fee schedule with the provider's discounted rates; and (3) a provision prohibiting the provider from charging plan members more than the discounted rates.

A provider network agreement must require that the provider network have written agreements with its providers that (1) contain the terms described above, (2) authorize it to contract with the medical discount plan organization on behalf of the provider, and (3) require it to maintain an up-to-date participating providers list that is given quarterly to the discount health plan organization.

A discount health plan organization must maintain a copy of each active provider agreement it has entered into. It is prohibited from contracting with a provider network that is not licensed as a preferred provider network.

PLAN REQUIREMENTS

The bill prohibits marketing, advertising, or selling a medical discount plan or using plan material that does not meet certain requirements. A plan or plan material must:

1. provide a clear and conspicuous disclosure that the plan is not insurance but only provides for discounted health care services from participating providers;

2. include the plan administrator's name, address, and telephone number;

3. have a toll-free telephone number through which a member can obtain a complete and accurate list of the local participating providers and applicable discounted services;

4. make a printed copy of the list available upon request and update it at least once every six months;

5. use plain language that does not lead to a misleading, deceptive, or fraudulent representation of the discounts;

6. provide notice of the consumer's right to cancel the plan

within 30 days of the discount health plan's receipt of membership fees for a full refund minus a reasonable processing fee; and

7. provide the refund within 30 days of receiving a member's timely cancellation.

The plan or plan material cannot (1) use the term "insurance," "health plan," "coverage," "copay," "copayments," "preexisting conditions," "guaranteed issue," "premium," "PPO," "preferred provider organization" or any other term that could lead a person to believe the plan is insurance, except in a disclaimer that the plan is not insurance. It can offer only discounted health care services or products that are authorized by a provider agreement.

The medical discount plan organization must issue at least one member discount card to each member. The cards must prominently include (1) a statement that the plan is not insurance and (2) the names, logos, or trademarks of any contracted provider network. The medical discount plan organization must provide the names of the networks to members upon request.

Each medical discount plan organization must (1) give the commissioner at least 30 days advance written notice if it changes its name or address, (2) maintain an up-to-date list of its participating providers' names and addresses on an Internet website, and (3) include its website address prominently on all plan material, including member discount cards.

FINES AND PENALTIES

The insurance commissioner may levy, collect, and deposit into the Insurance Fund the following fines:

1. up to $2,000 for a medical discount plan organization violating any applicable law;

2. up to $10,000 for a person who knowingly operates a medical discount plan organization that violates the plan requirements; and

3. up to $10,000 for a person who knowingly aids and abets

another that he knew or should have known was operating a medical discount plan organization that violates the plan requirements.

Anyone who collects medical discount plan membership fees but fails to provide the promised benefits is guilty of larceny. Under the penal code, larceny can be either a class A misdemeanor or a class B, C, or D felony depending on the property value at issue.

The commissioner may suspend a medical discount plan organization's authority to enroll new members and revoke or refuse to renew its license if the organization is (1) not in compliance with all applicable laws, (2) not fulfilling its obligations, or (3) hazardous to its members. If she has reasonable cause to believe that grounds exist for license suspension, non-renewal, or revocation, she must give the organization written notice of those grounds.

Her order suspending an organization's authority to enroll new members must specify when the suspension is effective and the conditions that must be met before the license may be reinstated to enroll new members. She may rescind or modify the order before the suspension period ends. She may not reinstate a license if (1) the organization does not request it and (2) the circumstances that led to the suspension still exist or are likely to recur.

When a medical discount plan organization's license is surrendered, not renewed, or revoked, it must immediately wind up and settle its affairs and cannot market, advertise, sell, collect fees on, or renew contracts as a medical discount plan organization.

BACKGROUND

Penalty for False Statement

A person who intentionally makes a false statement under oath to mislead a public official, is guilty of false statement in the 2nd degree, which is a class A misdemeanor, punishable by a fine up to $2,000, up to one year in prison, or both.

Related Bills

sSB 1249 (File 210), favorably reported by the Insurance and Real

Estate and Finance, Revenue and Bonding committees, modifies the definition of "preferred provider network" (PPN) and exempts non-risk-bearing networks from many of the current PPN requirements.

sSB 1144 (File 83), favorably reported by the Public Health and Insurance and Real Estate committees, excludes certain private clinical laboratories from the PPN definition.

sSB 929 (File 191), favorably reported by the Insurance and Real Estate Committee, requires each contract between an MCO or PPN and a physician to include an explanation of (1) physician payment methodology and timing and (2) the physician payment dispute resolution process. It also requires each MCO and PPN to give network physicians a payment-determining fee schedule.

Legislative History

On April 19, the House referred the bill to the Judiciary Committee, which reported it favorably on April 29. On May 10, the House referred it to the Finance, Revenue and Bonding Committee, which reported it favorably on May 16.

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable Substitute
Yea 16 Nay 0

Judiciary Committee

Joint Favorable Report
Yea 31 Nay 0

Finance, Revenue and Bonding Committee

Joint Favorable Report
Yea 45 Nay 0